STATEMENT OF EMERGENCY

907 KAR 20:050E

(1) This is an emergency administrative regulation which is being promulgated to comply with a federal mandate (Affordable Care Act) to authorize inpatient hospitals to make presumptive eligibility determinations for individuals whose Medicaid eligibility standard is a modified adjusted gross income (or MAGI.) The mandate is effective January 1, 2014; however, as the eligibility determination process for individuals in the MAGI group can begin October 1, 2013, this administrative regulation is necessary to be implemented on an emergency basis.

(2) This action must be implemented on an emergency basis to comply with a federal mandate.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation differs from this emergency administrative regulation as it does not state the implementation date as the ordinary regulation would not be adopted until after the implementation date.

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Steven L. Beshear
Governor

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Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Emergency Amendment)

907 KAR 20:050E[~~907 KAR 1:810~~]. Presumptive eligibility[~~ for pregnant women~~].

RELATES TO: KRS 205.520, 205.592, 42 USC 1396a(a)(47), r-1

STATUTORY AUTHORITY: KRS 194A.030(3), 194A.050(1), 205.520(3)[~~, EO 2004-726~~]

NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.~~] The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Kentucky's indigent citizenry~~]. KRS 205.592 establishes Medicaid eligibility requirements for pregnant women and children up to age one (1). This administrative regulation establishes requirements for the determination of presumptive eligibility and the provision of services to individuals[~~pregnant women~~] deemed presumptively eligible for Medicaid-covered services.

Section 1. [~~Definitions. (1) "Ambulatory prenatal care" means health-related care furnished to a presumed eligible pregnant woman provided in an outpatient setting.~~

~~(2) "Cabinet" means the Cabinet for Health and Family Services.~~

~~(3) "DCBS" means the Department for Community Based Services.~~

~~(4) "Department" means the Department for Medicaid Services or its designated agent.~~

~~(5) "Presumptive eligibility" means eligibility granted for Medicaid-covered services as specified in Section 6 of this administrative regulation to a qualified pregnant woman based on an income screening performed by a qualified provider.~~

~~(6) "Qualified provider" means a provider who:~~

~~(a) Is currently enrolled with the department;~~

~~(b) Has been trained and certified by the department to grant presumptive eligibility to pregnant women; and~~

~~(c) Provides services of the type described in 42 USC 1396d(a)(2)(A) or (B) or (9).~~

~~Section 2.~~] Providers Eligible to Grant Presumptive Eligibility. (1) A determination of presumptive eligibility regarding:

(a) A pregnant woman shall be made by a qualified provider who is:

1.[~~(1)~~] A family or general practitioner;

2.[~~(2)~~] A pediatrician;

3.[~~(3)~~] An internist;

4.[~~(4)~~] An obstetrician or gynecologist;

5.[~~(5)~~] A physician assistant;

6.[~~(6)~~] A certified nurse midwife;

7.[~~(7)~~] An advanced practice registered nurse[~~ practitioner~~];

8.[~~(8)~~] A federally-qualified health care center;

9.[~~(9)~~] A primary care center;

10.[~~(10)~~] A rural health clinic; [~~or~~]

11.[~~(11)~~] A local health department; or

(b) An individual whose income standard for Medicaid eligibility purposes is a modified adjusted gross income, shall be an inpatient hospital participating in the Medicaid program.

(2) An individual whose Medicaid eligibility is determined using the modified adjusted gross income as an income standard shall be:

(a) An individual:

1. Who is:

a. A child under the age of nineteen (19) years, excluding children in foster care;

b. A caretaker relative with income up to 133 percent of the federal poverty level;

c. A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;

d. An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

(i) Does not have a dependent child under the age of nineteen (19) years; and

(ii) Is not otherwise eligible for Medicaid benefits; or

e. A targeted low-income child with income up to 150 percent of the federal poverty level; and

(b) In accordance with 907 KAR 20:100.

Section 2.[~~3.~~]. Provider Responsibilities. (1) A qualified provider who determines that an individual[~~a pregnant woman~~] is presumptively eligible based on criteria established in Section 3[~~4~~] of this administrative regulation shall:

(a) Notify the department and obtain an authorization number;

(b) Inform the individual[~~woman~~] at the time the determination is made that the individual[~~she~~] is required to make an application for Medicaid benefits through the individual's[~~her~~] local DCBS office;

(c) Issue presumptive eligibility identification to the presumed eligible individual[~~woman~~]; and

(d) Maintain a record of the presumptive eligibility screening for each applicant.

(2) If an individual[~~a woman~~] is determined not to be presumptively eligible, the qualified provider shall inform the individual[~~woman~~] of the following in writing:

(a) The reason for the determination;

(b) That the individual[~~she~~] may file an application for Medicaid if the individual[~~she~~] wishes to have a formal determination made; and

(c) The location of the individual's[~~her~~] local DCBS office.

Section 3.[~~4.~~] Eligibility Criteria. Presumptive eligibility may be granted to:

(1) A woman if she:

(a)[~~(1)~~] Is pregnant;

(b)[~~(2)~~] Is a Kentucky resident;

(c) Does not have income exceeding 185 percent of the federal poverty level[~~(3) Meets income guidelines established in 907 KAR 1:640, Section 2(2)(a)~~];

(d)[~~(4)~~] Does not currently have a pending Medicaid application on file with the DCBS;

(e)[~~(5)~~] Is not currently enrolled in Medicaid;

(f)[~~(6)~~] Has not been previously granted presumptive eligibility for the current pregnancy; and

(g)[~~(7)~~] Is not an inmate of a public institution, except as established in 907 KAR 20:005, Section7(2).

(2) An individual whose Medicaid income eligibility standard is a modified adjusted gross income if the individual:

(a) Is a Kentucky resident;

(b) Does not have income exceeding:

1. 133 percent of the federal poverty level; or

2. 150 percent of the federal poverty level if the individual is a targeted low-income child;

(c) Does not currently have a pending Medicaid application on file with the DCBS;

(d) Is not currently enrolled in Medicaid; and

(e) Is not an inmate of a public institution except as established in 907 KAR 20:005, Section 7(2).

Section 4.[~~5.~~] Presumptive Eligibility Period. (1) Presumptive eligibility for an individual shall begin on the date on which a qualified provider:

(a) Determines that the individual[~~a woman~~] is presumptively eligible based on the criteria specified in Section 3[~~4 of this administrative regulation~~] if the qualified provider obtains an authorization number from the department on:

1. That day; or

2. If the department is closed, the next business day the department is open; or

(b) Obtains an authorization number from the department if it is not the day specified in paragraph (a) of this subsection.

(2) The presumptive eligibility period shall end on:

(a) The day preceding the date the presumptively-eligible individual[~~woman~~] is granted full eligibility in the Medicaid Program by the DCBS; or

(b) The last day of the second month following the month in which a qualified provider made the presumptive eligibility determination if the[~~a~~] presumed eligible individual[~~woman~~]:

1. Does not apply for the full Medicaid benefit package; or

2. Applies for and is found ineligible for the full Medicaid benefit package.

(3) To illustrate the presumptive eligibility period, if an individual became presumptively eligible on July 7, 2014, the individual would remain presumptively eligible through September 30, 2014.

(4)[~~(3)~~ For a woman who gain presumptive eligibility by being pregnant, only one (1) presumptive eligibility period shall be granted for each episode of pregnancy.

Section 5.[~~6.~~] Covered Services. (1)(a) Payment for a covered service provided to a presumptively-eligible individual[~~pregnant woman~~] shall be in accordance with the current Medicaid reimbursement policy for the service unless the service is provided to an individual who is enrolled with a managed care organization[~~reimbursement~~].

(b) A managed care organization:

1. Shall not be required to reimburse in the same manner or amount as the department reimburses for a Medicaid-covered service provided to a presumptively eligible individual; or

2. May elect to reimburse in the same manner or amount as the department reimburses for a Medicaid-covered service provided to a presumptively eligible individual.

(2) Covered services for a presumptively-eligible:

(a) Pregnant woman shall be limited to ambulatory prenatal care services delivered in an outpatient setting and shall include:

1.[~~(a)~~ Services furnished by a primary care provider, including:

a.[~~1.~~] A family or general practitioner;

b.[~~2.~~] A pediatrician;

c.[~~3.~~] An internist;

d.[~~4.~~] An obstetrician or gynecologist;

e.[~~5.~~] A physician assistant;

f.[~~6.~~] A certified nurse midwife; or

g.[~~7.~~] An advanced practice registered nurse[~~ practitioner~~];

2.[~~(b)~~] Laboratory services provided in accordance with 907 KAR 10:014[~~907 KAR 1:014~~] and 907 KAR 1:028;

3.[~~(c)~~] X-ray services provided in accordance with 907 KAR 10:014[~~907 KAR 1:014~~] and 907 KAR 1:028;

4.[~~(d)~~] Dental services provided in accordance with 907 KAR 1:026, Section 2(1) and (2);

5.[~~(e)~~] Emergency room services provided in accordance with 907 KAR 10:014[~~907 KAR 1:014, Section 1(1)(c)~~];

6.[~~(f)~~] Emergency and nonemergency transportation provided in accordance with 907 KAR 1:060;

7.[~~(g)~~] Pharmacy services provided in accordance with 907 KAR 1:019[~~907 KAR 1:019E~~];

8.[~~(h)~~] Services delivered by rural health clinics provided in accordance with 907 KAR 1:082;

9.[~~(i)~~] Services delivered by primary care centers and federally-qualified health care centers provided in accordance with 907 KAR 1:054; or

10.[~~(j)~~] Primary care services delivered by local health departments provided in accordance with 907 KAR 1:360; or

(b) Individual who is not a pregnant woman shall include:

1. Services furnished by a primary care provider, including:

a. A family or general practitioner;

b. A pediatrician;

c. An internist;

d. An obstetrician or gynecologist;

e. A physician assistant;

f. A certified nurse midwife; or

g. An advanced practice registered nurse;

2. Laboratory services provided in accordance with 907 KAR 10:014 and 907 KAR 1:028;

3. X-ray services provided in accordance with 907 KAR 10:014 and 907 KAR 1:028;

4. Dental services provided in accordance with 907 KAR 1:026, Section 2(1) and (2);

5. Emergency room services provided in accordance with 907 KAR 10:014;

6. Emergency and nonemergency transportation provided in accordance with 907 KAR 1:060;

7. Pharmacy services provided in accordance with 907 KAR 1:019;

8. Services delivered by rural health clinics provided in accordance with 907 KAR 1:082;

9. Services delivered by primary care centers and federally-qualified health care centers provided in accordance with 907 KAR 1:054; or

10. Primary care services delivered by local health departments provided in accordance with 907 KAR 1:360;

11. Inpatient or outpatient hospital services provided by a hospital.

Section 6.[~~7.~~] Appeal Rights. (1) The appeal rights of the Medicaid Program shall not apply if an individual[~~a woman~~] is:

(a) Determined not to be presumptively eligible; or

(b) Determined to be presumptively eligible but fails to file an application for Medicaid with the DCBS before the individual's[~~her~~] presumptive eligibility ends and therefore is determined to be ineligible for Medicaid benefits.

(2) The appeal rights of the Medicaid Program shall apply if an individual[~~a woman~~] is:

(a) Determined to be presumptively eligible; and

(b) Files an application with the DCBS but is determined ineligible for Medicaid benefits.

(3) Except as specified in subsection (1) of this section, an appeal of a negative action taken by the department regarding a Medicaid recipient shall be in accordance with:

(a) 907 KAR 1:563 if the individual is:

1. Not enrolled with a managed care organization; or

2. Enrolled with a managed care organization and the individual has exhausted the MCO internal appeal process in accordance with 907 KAR 17:010 and requests an appeal of an adverse decision by the MCO; or

(b) 907 KAR 17:010 if the individual is enrolled with a managed care organization.

(4) Except as specified in subsection (1) of this section, an appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(5) An appeal of a negative action regarding a Medicaid provider shall be in accordance with 907 KAR 1:671.

Section 8. Quality Assurance and Utilization Review. The cabinet shall evaluate, on a continuing basis, access, continuity of care, health outcomes, and services arranged or provided by a Medicaid provider to a presumptively eligible individual[~~presumed eligible woman~~] in accordance with accepted standards of practice for medical service.

Section 9. Implementation Date. (1) An inpatient hospital shall be authorized to make presumptive eligibility determinations beginning on January 1, 2014.

(2) An individual shall not be eligible to receive Medicaid benefits as a result of a presumptive eligibility determination made by an inpatient hospital any earlier than

January 1, 2014.

907 KAR 20:050E

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 20:050E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Marchetta Carmicle (502) 564-6204 or Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes Medicaid eligibility provisions regarding presumptive eligibility. Presumptive eligibility is a program designed to improve pregnant women's access to outpatient prenatal care. Providers authorized to make presumptive eligibility determinations complete an application to determine whether a given pregnant woman qualifies for Medicaid under this program. If the provider determines that the woman is eligible, the provider will be reimbursed for prenatal services provided to the woman.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid eligibility provisions regarding presumptive eligibility.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid eligibility provisions regarding presumptive eligibility.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing Medicaid eligibility provisions regarding presumptive eligibility.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment to this administrative regulation authorizes inpatient hospitals to make presumptive eligibility determinations for all individuals for whom a modified adjusted gross income is the Medicaid income eligibility standard and deletes the definitions. Hospitals are not required to make presumptive eligibility determinations but will be authorized to do so. The provider types who were previously authorized to make presumptive eligibility determinations regarding pregnant women will continue to be authorized to do so, but not for all individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard.
(b) The necessity of the amendment to this administrative regulation: Authorizing inpatient hospitals to make presumptive eligibility determinations for all individuals for whom a modified adjusted gross income is in the Medicaid income eligibility standard is necessary to comply with an Affordable Care Act mandate.

Deleting the definitions is necessary as the Department for Medicaid Services (DMS) is creating a definitions administrative regulation for Chapter 20 – the new chapter which will house all Medicaid eligibility administrative regulations.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the Affordable Care Act by establishing that inpatient hospitals will be authorized to make presumptive eligibility determinations.

(d) How the amendment will assist in the effective administration of the statutes: This amendment assists in the effective administration of the Affordable Care Act by establishing that inpatient hospitals will be authorized to make presumptive eligibility determinations.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All inpatient hospitals participating in Kentucky's Medicaid program will be authorized to make presumptive eligibility decisions for individuals whose Medicaid eligibility standard is a modified adjusted gross income (MAGI) but are not required to do so. Medicaid recipients who may gain presumptive eligibility coverage as a result of an inpatient hospital's determination will be affected. Currently, there are over 100 inpatient hospitals participating in Kentucky's Medicaid program. The Department for Medicaid Services (DMS) estimates that over 500,000 individuals could be eligible for Medicaid under the modified adjusted gross income (MAGI) rules in state fiscal year 2014.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Inpatient hospitals who wish to make presumptive eligibility determinations will have to complete the required application for each applicant to determine if the individual qualifies via the presumptive eligibility option.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Inpatient hospitals will benefit by making determinations and being reimbursed for services provided to individuals for whom the hospital determined is eligible via the presumptive eligibility option. Individuals determined to be presumptive eligible by an inpatient hospital will benefit by receiving Medicaid-covered services during the presumptive eligibility period. Additionally, individuals will hopefully be prompted, as a result of receiving presumptive eligibility for Medicaid benefits, to apply for "standard" Medicaid coverage (before their presumptive eligibility period ends) and remain eligible for Medicaid benefits.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) is unable to estimate how many individuals could be determined to be presumptively eligible by inpatient hospitals or to predict how many hospitals will choose to make presumptive eligibility determinations. DMS projects that over 500,000 individuals will be in the eligibility group (the MAGI group) which could be made presumptively eligible by inpatient hospitals; however, the same individuals can gain eligibility without being admitted to an inpatient hospital. As it's difficult to predict how hospitals will make presumptive eligibility determinations and how many individuals will gain Medicaid eligibility as a result of a presumptive eligibility determination, it is difficult to estimate costs associated with inpatient hospital presumptive eligibility determinations.

(b) On a continuing basis: The answer in paragraph (a) also applies here.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under Title XIX of the Social Security Act and state general funds.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding is necessary to implement the administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The administrative regulation neither directly nor indirectly establishes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering is applied in the sense that inpatient hospitals can only make presumptive eligibility determinations for those whose Medicaid eligibility standard is a modified adjusted gross income (MAGI). The Affordable Care Act authorizes hospitals to make such determinations for only the MAGI population.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 20:050E
Agency Contact Person: Marchetta Carmicle (502) 564-6204 or Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. The presumptive eligibility option is not mandatory. The requirements regarding the program, for states who choose to offer it, are established in 42 U.S.C. 1396r-1, 42 U.S.C. 1396a(a)(47), and 42 U.S.C. 1396b(u)(1)(D)(v).

2. State compliance standards. KRS 205.520(3) authorizes the cabinet to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

3. Minimum or uniform standards contained in the federal mandate. The presumptive eligibility option is not federally mandated; however, if a state chooses to offer it the following requirements apply:

42 U.S.C. 1396a(a)(47) establishes that any hospital participating in the Medicaid program may "elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period . . . "

42 U.S.C. 1396b(u)(1)(D)(v) establishes that the federal government (Centers for Medicare and Medicaid Services) will not consider federal Medicaid funds spent on services to an individual who was erroneously determined to be presumptively eligible by a hospital (that chose to make presumptive eligibility determinations) to be an "erroneous excess payment for medical assistance" (i.e. an erroneous excess Medicaid expenditure.) The result of the policy is that CMS will not seek to recover such expenditure from the given state.

"42 U.S.C. 1396b(u)(1)(D)(v) – Limitation of Federal Financial Participation in Erroneous Medicaid Assistance Expenditures
(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)), for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section, for medical assistance provided to an individual described in subsection (a) of section 1920B during a presumptive eligibility period under such section, or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose."

42 U.S.C. 1396r-1 defines the presumptive eligibility period for a pregnant woman and providers qualified to render presumptive eligibility determinations.

It defines the presumptive eligibility period as follows:
"(A) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman does not exceed the applicable income level of eligibility under the State plan, and
(B) ends with (and includes) the earlier of—
(i) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan, or
(ii) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination referred to in subparagraph (A), such last day."

It defines qualified provider as follows:

"any provider that—
(A) is eligible for payments under a State plan approved under this title,
(B) provides services of the type described in subparagraph (A) or (B) of section 1905(a)(2) or in section 1905(a)(9),
(C) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A), and
(D) (i) receives funds under—
(I) section 330 or 330A of the Public Health Service Act,
(II) title V of this Act, or
(III) title V of the Indian Health Care Improvement Act;
(ii) participates in a program established under—
(I) section 17 of the Child Nutrition Act of 1966, or
(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973;
(iii) participates in a State perinatal program; or
(iv) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).

The term 'qualified provider' also includes a qualified entity, as defined in section 1920A(b)(3)."

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? It does not impose stricter, additional, or different responsibilities or requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. It does not impose stricter, additional, or different responsibilities or requirements.

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FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 20:050E
Agency Contact Person: Marchetta Carmicle (502) 564-6204 or Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The Department for Medicaid Services (DMS) is unable to estimate how many individuals could be determined to be presumptively eligible by inpatient hospitals or to predict how many hospitals will choose to make presumptive eligibility determinations. DMS projects that over 500,000 individuals will be in the eligibility group (the MAGI group) which could be made presumptively eligible by inpatient hospitals; however, the same individuals can gain eligibility without being admitted to an inpatient hospital. As it's difficult to predict how hospitals will make presumptive eligibility determinations and how many individuals will gain Medicaid eligibility as a result of a presumptive eligibility determination, it is difficult to estimate revenues associated with inpatient hospital presumptive eligibility determinations.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The answer in paragraph (a) also applies here.
   (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) is unable to estimate how many individuals could be determined to be presumptively eligible by inpatient hospitals or to predict how many hospitals will choose to make presumptive eligibility determinations. DMS projects that over 500,000 individuals will be in the eligibility group (the MAGI group) which could be made presumptively eligible by inpatient hospitals; however, the same individuals can gain eligibility without being admitted to an inpatient hospital. As it's difficult to predict how hospitals will make presumptive eligibility determinations and how many individuals will gain Medicaid eligibility as a result of a presumptive eligibility determination, it is difficult to estimate costs associated with inpatient hospital presumptive eligibility determinations.

(d) How much will it cost to administer this program for subsequent years? The answer in paragraph (c) also applies here.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): .

Expenditures (+/-):